WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

(Form Updated: 11/20/2008)

COMMITTEE NOTICES ...

➢ *Committee Reports* ... *CR*
**

➢ *Executive Sessions* ... *ES*
**

➢ *Public Hearings* ... *PH*
**

➢ *Record of Comm. Proceedings* ... *RCP*
**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

➢ *Appointments* ... *Appt*
**

Name:

➢ *Clearinghouse Rules* ... *CRule*
**

➢ *Hearing Records* ... *HR* *(bills and resolutions)*
**

➢ *Miscellaneous* ... *Misc*

05hr_AC-In_Misc_pt56b

(2005 documents)

MEMORANDUM

TO: REPRESENTATIVE GIELOW; MEMBERS OF SPEAKER'S TASK FORCE ON MEDICAL MALPRACTICE

FROM: DAVID STRIFLING

SUBJECT: POTENTIAL RECOMMENDATIONS TO ASSEMBLY

DATE: 11/11/2005

CC:

Rep. Gielow:

After reviewing the testimony and documents submitted to our task force, and performing some additional research and analysis of my own, I hereby respond to your request for ideas via this memo summarizing my thoughts as to what recommendations our task force should send the Assembly.

This memo is divided into three parts. Part I contains my ideas and recommendations relating to the proposed cap on noneconomic damages in medical malpractice actions. Much of the testimony we heard and the information we received addressed the question of whether Wisconsin should have a cap, and whether caps in general are effective. However, given the directions our task force received from the Speaker, that is not the question with which this task force is concerned. Our mission is not to decide whether caps are necessary; rather, it is to come up with a form of the cap that is acceptable and fair. Accordingly, this memo does not attempt to address whether Wisconsin should have a cap, or whether caps have a positive effect on the overall health care climate. Nevertheless, I stress that in my opinion, if the legislature decides to re-enact the cap in some form, it must support that decision with a substantial amount of legislative history justifying the cap, as the absence of such justification was one of the grounds on which the Ferdon court struck down the cap.

Part II of this memo contains my thoughts relevant to the situation of medical residents vis-à-vis Chapter 655 of the Wisconsin Statutes, the noneconomic damages cap, and the Injured Patients and Families Compensation Fund (Fund). Part III covers the collateral source rule and Wis. Stat. § 893.55(7). Certainly, the information presented to us has focused almost exclusively on the cap, and not on the medical resident issue or the collateral source rule. Nonetheless, at our first session we briefly discussed the possibility of providing information on those issues as well, and so I have.

Before beginning my discussion of potential legislative options, however, I feel that it would be worthwhile to address the goal of medical malpractice tort reform. In short, I believe the goal of such reform should not solely be to attract and retain physicians; rather, the goal should be to attract and retain the best doctors, so that Wisconsin is not only an excellent environment in which to practice health care, but is also an excellent environment to receive health care.

With this in mind, I undertook a brief statistical analysis to see whether previous tort reforms in this state had had such an effect. I analyzed publicly available data to determine, on a state-by-state basis, the number of physicians per successful malpractice claim.[1]

My conclusion: Wisconsin doctors are among the best in the country. My study revealed that as of 2000, there were 105 Wisconsin physicians for every one successful malpractice claim. By far, this was the best ratio in the nation. In the lowest ranked state under my methodology, West Virginia, there was one successful malpractice claim for every 13 physicians!

In my view, the Wisconsin medical profession may have done too little to inform Wisconsin's residents about the high quality of health care available in this state. My inexact study could be replicated on a much larger scale to prove that Wisconsin's doctors are among the nation's best. In order to keep this "cream of the crop" at home, Wisconsin should do all it can to ensure that it remains a favorable environment to both practice and receive health care. With that in mind, I move on to my thoughts regarding the three issues facing our task force:

I. Cap on noneconomic damages in medical malpractice actions

If the legislature reenacts the cap, it must do so in a form that addresses the constitutional concerns discussed in the Wisconsin Supreme Court's opinion in Ferdon v. Wisconsin Patients Compensation Fund. First, the new legislation must address the majority opinion's conclusion that the former cap violated the Wisconsin Constitution's guarantee of equal protection of the laws in three ways: 1) By discriminating against the most severely injured claimants; 2) By discriminating against the youngest claimants; 3) By discriminating against claimants with families.

In assessing the constitutionality of a future cap, it must be remembered that much of the majority opinion is dedicated to attacking the effectiveness of caps as a whole. It is doubtful that Chief Justice Shirley S. Abrahamson – the author of the majority opinion – or Justice Ann Walsh Bradley – who joined the opinion without comment – could ever vote to find any cap constitutional in light of the majority opinion. The three dissenting Justices – Jon P. Wilcox, David T. Prosser, and Patience D. Roggensack – would likely vote that a future cap is constitutional. The two key votes may be those of the concurring Justices – N. Patrick Crooks and Louis B. Butler.

In a somewhat cryptic concurring opinion, Justice Crooks (joined by Justice Butler) noted that caps "can satisfy the requirements of the Wisconsin Constitution." This simple statement is out of step with much of the majority opinion, and it deserves further attention. The problem, according to Justice Crooks, is that the current cap is too low, and further that the legislature arbitrarily set the cap

[1] My methodology was as follows: first, I recorded the population of each state, as reported in the 2000 United States Census. Second, I determined the number of practicing physicians in each state. I used the data provided to our task force by the Wisconsin Academy of Trial Lawyers (WATL) in the report entitled "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians." This report provided the number of physicians per 100,000 residents in all 50 states as of the year 2000. Next, I recorded the number of successful malpractice claims during the year 2000 in all fifty states, as reported by the United States Department of Health and Human Services "National Practitioners' Database 2003 Annual Report," which is publicly available on the Internet. Finally, I divided the total number of physicians in each state by the total number of malpractice claims in that state, all with respect to the year 2000. Complete results are contained in the attached spreadsheet. Using this admittedly inexact science, Wisconsin ranked first in the nation in least malpractice claims per number of physicians.

amount at $350,000. Justice Crooks noted that in 1995, the cap amount was changed from $250,000 to $350,000 at the last minute, with no explanation.

Each of these concerns must be addressed.

The first question the legislature must answer is what form the cap should take. In this regard, it is useful to examine what other states with similar caps have done. My research revealed 27 other states that have enacted some form of damage caps applicable to medical malpractice actions. In five of these states, the caps cover all damages, not just noneconomic damages – a situation decidedly different from Wisconsin's. Accordingly, I restricted my analysis to the 22 states with caps on noneconomic damages alone. (A summary table displaying the salient features of these caps is attached as a separate spreadsheet.) The caps enacted by those states generally took five forms:

- An immutable cap, not adjusted for inflation, with no allowances for the severity of the claimant's injury or the claimant's age (8 states)
- A cap that is adjusted yearly for inflation, but contains no allowances for the severity of the claimant's injury or the claimant's age (5 states)
- A base cap that is adjustable based on the severity of the claimant's injury (9 states) (some of these caps are also adjustable for inflation)
- A cap that is based on the claimant's age (1 state - Alaska, which has a $400,000 base cap, alternatively allows the claimant to receive the higher of $400,000 or $8000 multiplied by the claimant's life expectancy).
- A cap that is based on the amount of economic damages received (1 state – Ohio, which has a $250,000 base cap, alternatively allows the claimant to receive the greater of $250,000 or 3 times economic damages up to $350,000 per plaintiff).

I suggest incorporating several of these ideas, as follows:

Set a base cap on noneconomic damages at $500,000. In the 22 states mentioned above, the cap amount ranges from a low of $250,000 (California, Idaho, Kansas, Montana, Texas, and West Virginia) to a high of $650,000 (Maryland). The average cap amount is about $390,000. In Wisconsin, the pre-Ferdon cap (as adjusted for inflation) was $455,755. This represented an increase of about $23,000 over last year's cap amount of $432,352.[2] Accordingly, one might have expected the cap level to be about $475,000-$480,000 in 2006. A $500,000 cap would be greater than the caps in 14 of the 22 other states that have enacted caps, and it would be equal to 6 other states' caps. Only 2 of the 22 caps would be higher than Wisconsin's (Maryland ($650,000) and Missouri ($565,000 as adjusted for inflation)).

This information is especially informative in light of the Ferdon concurrence. Justice Crooks expressed surprise that Wisconsin's cap could bounce from $1,000,000 to nothing to $350,000, finding this arbitrary. The statistics from other cap states reveal that the $1,000,000 cap was quite high in comparison with caps in other states.

Adjust the base cap yearly to allow for inflation. This feature, carried over from the old cap, will allow the cap amount to remain fair over longer periods of time without requiring frequent legislative adjustment.

[2] Source: materials submitted to the Task Force by the Wisconsin Commissioner of Insurance.

Increase the cap in cases involving minor children by indexing the cap based on life expectancy. As noted above, this approach is practiced in only one other state (Alaska). However, the Ferdon decision calls for unusual measures. In Wisconsin, the current life expectancy for a newborn baby is about 78.8 years (statistic provided by the Wisconsin Department of Health and Family Services, available online at www.dhfs.state.wi.us/stats/01-03life.htm). If Wisconsin followed Alaska's example and set the cap at $8000 multiplied by one's life expectancy, the results would be as follows:

Age Group	Average Life Expectancy	Noneconomic Damage Cap
0	78.8	$630,400
1-4	78.3	$626,400
5-9	74.4	$595,200
10-14	69.5	$556,000
15-18	64.6	$516,800
18 and over	-	$500,000

This provision would attempt to address the Supreme Court's concern that the existing cap discriminates against younger claimants.

Create a secondary cap for severely injured claimants. Consider creating a secondary cap (perhaps at $750,000) to compensate the most severely injured claimants. This approach is practiced in several other states. The statutory language triggering the secondary cap could be very simple ("severe and catastrophic injuries") or extremely specific, spelling out particular injuries. For example, in Florida, the secondary cap is automatically triggered when negligence results in a permanent vegetative state, and may be invoked by the triet of fact if the negligence caused a spinal cord injury involving severe paralysis; an amputation; a severe brain injury; severe burns; blindness; or loss of reproductive organs. A provision like this would attempt to address the Supreme Court's concern that the existing cap discriminates against severely injured patients. As with the base cap, this secondary cap could also be indexed for inflation, and could also be adjustable based on the claimant's life span (perhaps at $12,000 multiplied by the expected life span?). Of course, no matter how high the cap is set, some injuries will not be fully compensated. That is the fundamental nature of a cap.

Do not provide for adjustment of the cap based on a percentage of economic damages. This option, used as an alternative method in Ohio, has some attraction if only because Justice Butler repeatedly raised it as a possibility during oral argument in the Ferdon case. (A digital audio file of the Ferdon oral argument is online and available to the public at www.wicourts.gov.) However, such a cap is really no cap at all, because in a case with huge economic damages, the available noneconomic damages would also be very large. In other words, such a cap would not protect the Fund from the feared "one big case" that could severely hamstring it. From a practical standpoint, because of the limited availability of data, it might be difficult to fairly set the percentage of economic damages at which to set the noneconomic damage cap.

Do not alter the cap for a particular claimant based on the size of the claimant's family. Few other states allow modification based on the number of claimants. Such modification opens claims of equal protection violation no matter what is done; for example, if the cap is increased for claimants with multiple family members, does that discriminate against claimants with little or no family? This part of the Ferdon majority opinion may prove very difficult to address.

Consider an "escape hatch" for health care providers in high-risk areas such as emergency care or OB-GYN care. The legislature might consider special provisions applicable to certain high-

risk classes of health care providers – perhaps these providers would not be subject to the secondary cap?

Do not make the new cap retroactive. The idea of making the new cap retroactive may be appealing in order to cover the current period in which uncapped noneconomic damages may be had. However, the legislature should be aware that the Wisconsin Supreme Court declared a similar provision unconstitutional in Martin v. Richards, 192 Wis. 2d 156, 531 N.W.2d 70 (1995).

A constitutional amendment should be the last resort. Such an amendment would be very difficult to pass, and would probably take several years to become effective.

Do everything possible to bring all sides to a compromise. Obviously, this is much easier said than done. However, I believe it should be attempted. As Governor Doyle's spokesperson stated, "the governor has encouraged all sides and all interested parties to work together on this to try to come up with a solution that meets the concerns that the court has set out." (Quote taken from Milwaukee Journal Sentinel, 8/30/2005). The Governor would probably be more likely to support a bill that contained input from all sides. Perhaps the Wisconsin Association of Trial Lawyers could be induced to come to the table in exchange for the cap multipliers described above, or alternatively for some form of increased oversight over the insurance community or the medical community. For example, the recently-passed bill reenacting a cap on noneconomic damages in Illinois contained a provision requiring regulatory approvals for medical malpractice insurers seeking certain rate increases.

To provide some concrete examples of how the cap format I have proposed in this memo would work, the following table, adapted from the information WATL provided, displays the nine cases affected by the cap over the past ten years:

Name, Age, Date, County	Injury	Jury Award	Effect of old cap	Effect of new cap
Joseph Richard, mid-50s, 2005, Milwaukee	Unnecessary removal of rectum	$540,000	Reduced to $432,252 (20% reduction)	Reduced to $500,000 (7% reduction)
David Zak, mid-30s, 2004, Marinette	Failure to diagnose infection	$1,000,000	Reduced to $422,632 (57% reduction)	Reduced to $500,000 (50% reduction)
Helen Bartholomew, early 60s, 2004, Kenosha	Failure to diagnose heart attack	$1,200,000	Reduced to $350,000 (70% reduction)	Reduced to $500,000 (58% reduction)
Sean Kaul, infant, 2003, Ozaukee	Permanent disability due to negligent diagnosis	$930,000	Reduced to $422,632 (55% reduction)	Not reduced.[1]
Matthew Ferdon, infant, 2002, Brown	Right arm paralysis due to negligent delivery	$700,000	Reduced to $410, 322 (40% reduction)	Not reduced.[1]
Scott Dickinson, mid-30s, 2002, Dane	Rendered a quadriplegic due to negligent treatment	$6,500,000	Reduced to $410,322 (93% reduction)	Reduced to $750,000 (88% reduction)

Name, Age, Date, County	Injury	Jury Award	Effect of old cap	Effect of new cap
Kristopher Brown, 16, 2001, Eau Claire	Negligent treatment of broken leg results in amputation	$1,350,000	Reduced to $404,657 (67% reduction)	Reduced to $775,200 (43% reduction)[1]
Bonnie Richards, early 40s, 2000, Eau Claire	Damage to bile duct resulting in hernias	$660,000	Reduced to $381,428 (41% reduction)	Reduced to $500,000 (24% reduction)
Candice Sheppard, mid-20s, 1999, Portage	Permanent pain and injury due to negligent cyst removal	$700,000	Reduced to $350,000 (50% reduction)	Reduced to $500,000 (29% reduction)

[1] Assumes that this case would be subject to secondary cap, as indexed for minor child's life expectancy (12,000 * life expectancy.)

This table shows that a cap similar to the one I have proposed in this memo would have produced dramatically different results in some of these cases, and very similar results in others.

WATL and other cap opponents have pointed out that these nine cases represent such a small number of the total malpractice cases that caps really aren't necessary. In my view, the purpose of the cap is not to affect a larger number of cases – on the contrary, the smaller the number of cases affected, the better. Rather, the caps are intended to provide predictability; in other words, to serve as a safety valve that protects the whole system – and especially the Fund – from one extremely large award.

In selecting the above provisions, it was my intention to arrive at an equitable compromise that would ensure fairness for legitimate victims of medical malpractice while protecting health care providers and the Fund from the huge awards that have deleteriously affected the medical climate in other states. The dollar amounts discussed above are certainly debatable, and may be edited by the task force or the legislature. However, whatever final number is agreed upon must be supported by hard data to avoid the Ferdon concurrence's concern of arbitrariness.

II. Medical Residents

In Phelps v. Physicians Insurance Company, a case decided earlier this year, the Wisconsin Supreme Court ruled that unlicensed first-year medical residents are not health care providers, and therefore are not subject to the protections of Chapter 655 (such as the Fund) or the noneconomic damage cap, unless those unlicensed first-year residents are "borrowed employees" of a health care provider such as a hospital.

Our task force has heard very limited testimony on this issue. Certainly, the Phelps decision has not created the same level of consternation as has the Ferdon decision. It is, however, an ancillary issue. We may wish to present the Assembly with some information about it.

Chapter 655 of the statutes, which provides Fund coverage and certain other protections for health care providers, contains provisions governing the applicability of that chapter. Currently, the main applicability provision limits the Chapter's coverage to physicians, registered nurses, and certain

businesses such as hospitals. Wis. Stat. § 655.002. Another provision extends coverage to employees of health care providers. Wis. Stat. § 655.005.

Of course, many residents are employed by the hospitals they work in, and are therefore clearly covered by the "employee" provision. Residents working in state-owned hospitals might also be covered by the cap on damages in actions against state employees. The brunt of the Phelps decision falls on unlicensed first-year residents in programs administered by the Medical College of Wisconsin Associated Hospitals (MCWAH). These residents are employed by MCWAH, but it is questionable whether MCWAH (a purely administrative nonprofit corporation) is a health care provider. The key issue is whether the MCWAH residents are also "borrowed employees" of the actual hospitals in which they work. This question is resolved on an individual, case-by-case basis.

MCWAH employs about 140 first-year residents in 25 disciplines. (http://www.mcw.edu/display/router.asp?docid=2422). These are the residents most at risk as a result of the Phelps decision. The legislature may also wish to consider the effect this decision might have on Wisconsin's ability to attract medical residents who would eventually become Wisconsin doctors.

At first glance, it might appear that if the legislature wished to provide cap and/or Fund coverage to unlicensed first-year residents, the easiest way to do so would be to amend Wis. Stat. § 655.002(1) to include unlicensed first year residents.

However, this issue is not as simple as it seems. Theresa Wedekind, Director of the Fund, informed me that unlicensed first-year residents do not pay into the Fund. It would seem inequitable for the Fund to provide coverage without receiving an assessment from these residents. This could be handled by adjusting the Fund regulations to collect such an assessment, but that is not something the legislature could do on its own.

Another option would be to amend Wis. Stat. § 893.55(4)(b), the statute enumerating who is covered by the cap, to specifically include unlicensed first-year residents. This would give those residents the benefit of cap coverage, but would not allow them to tap into the Fund.

III. Collateral Source Rule

The third issue before us concerns the applicability of the collateral source rule in medical malpractice actions. This issue stems from the Wisconsin Supreme Court's decision in Lagerstrom v. Myrtle Werth Hospital, in which the court largely eviscerated Wis. Stat. §893.55(7), which provides:

(7) Evidence of any compensation for bodily injury received from sources other than the defendant to compensate the claimant for the injury is admissible in an action to recover damages for medical malpractice. This section does not limit the substantive or procedural rights of persons who have claims based upon subrogation.

The court held that this section allows evidence of collateral source payments to be presented to the jury; however, the jury cannot reduce the plaintiff's award based on such evidence. The court essentially held that the statute gives the jury too much discretion because the text "does not inform a fact-finder what to do with the evidence." Accordingly, the court delved into legislative history and "common law concepts" to reach its conclusion.

Should the legislature wish to address this decision, it would have to modify Wis. Stat. § 893.55(7) to inform the fact-finder what it must do with evidence of collateral sources. Presumably, the intent of the change would be to force the fact-finder to reduce the plaintiff's award by any collateral source payments received. Similar provisions have been held constitutional in other states, although there is no guarantee that the Wisconsin Supreme Court would so hold. In the interest of fairness, the legislature could also amend the statute to provide that the plaintiff should be allowed to inform the fact-finder of any collateral obligations it has, such as an obligation to reimburse Medicare.

I look forward to discussing these preliminary ideas at our next meeting. As its final product, I believe our task force should produce a detailed report recording our recommendations and laying out the evidence supporting them.

State	2000 Pop	Phys/100K	Total Physicians	Successful Claims	Phys/Claim
Wisconsin	5,363,675	137	7348	70	105
Virginia	7,078,515	215	15219	199	76
Hawaii	1,211,537	239	2896	40	72
Minnesota	4,919,479	126	6199	86	72
Massachusetts	6,349,097	331	21016	323	65
Oregon	3,421,399	148	5064	81	63
Vermont	608,827	231	1406	23	61
North Carolina	8,049,313	153	12315	215	57
Connecticut	3,405,565	273	9297	167	56
Alabama	4,447,100	98	4358	82	53
Delaware	783,600	203	1591	30	53
Maryland	5,296,486	239	12659	248	51
New Hampshire	1,235,786	263	3250	64	51
North Dakota	642,200	125	803	16	50
Alaska	626,932	130	815	17	48
Rhode Island	1,048,319	299	3134	67	47
California	33,871,648	187	63340	1396	45
Colorado	4,301,261	140	6022	143	42
South Carolina	4,012,012	128	5135	124	41
Washington	5,894,121	142	8370	210	40
Indiana	6,080,485	108	6567	168	39
Maine	1,274,923	196	2499	65	38
Idaho	1,293,953	95	1229	33	37
Arkansas	2,673,400	92	2460	69	36
New Jersey	8,414,350	250	21036	609	35
Tennessee	5,689,283	106	6031	179	34
Nebraska	1,711,263	113	1934	59	33
South Dakota	754,844	110	830	26	32
Georgia	8,186,453	104	8514	274	31
Pennsylvania	12,281,054	192	23580	874	27
Louisiana	4,468,976	112	5005	188	27
Wyoming	493,782	135	667	26	26
Oklahoma	3,450,654	73	2519	103	24
New Mexico	1,819,046	119	2165	89	24
Arizona	5,130,632	120	6157	263	23
Missouri	5,595,211	82	4588	196	23
Utah	2,233,169	109	2434	105	23
Mississippi	2,844,658	94	2674	116	23
Illinois	12,419,293	108	13413	589	23
Iowa	2,926,324	89	2604	121	22
Kentucky	4,041,769	99	4001	186	22
Kansas	2,688,418	97	2608	122	21
Florida	15,982,378	150	23974	1223	20
New York	18,976,457	212	40230	2103	19
Michigan	9,938,444	125	12423	659	19
Montana	902,195	131	1182	67	18
Texas	20,851,820	89	18558	1115	17
Nevada	1,998,257	96	1918	116	17
Ohio	11,353,140	120	13624	846	16
West Virginia	1,808,344	124	2242	169	13

States with caps on noneconomic damages	Cap Dollar Amount	Is cap adjusted for inflation?	Is cap otherwise adjustable?	Stat Cite	Notes
Alaska	$ 400,000	No	Can also use $8,000 x life expectancy; for "severe permanent physical impairment or severe disfigurement," use $1 million or $25,000 x life expectancy	Alaska Stat. 09.17.010	
California	$ 250,000	No	No	Cal. Civ. Code 3333.2	
Colorado	$ 300,000	No	No	Colo. Rev. Stat. 13-64-302	
Florida	$ 500,000	No	$1,000,000 if result was death or permanent vegetative state, or for certain other catastrophic injuries if equitable	Fla. Stat. Ch. 766.118	
Hawaii	$ 375,000	No	Exceptions for certain damages	Haw. Rev. Stat. 663-8.7	
Idaho	$ 250,000	Yes	No	Idaho Code 6-1603	
Illinois	$ 500,000	No	Raised to $1000000 vs hospitals	S.B. 475	(8/27/05)
Kansas	$ 250,000	No	No	Kans. Stat. Ann. 60-19a02	
Maryland	$ 650,000	Annual 15000 increase; starting in 2009	If multiple claimants, may get 125% of cap	Md. Code Ann. Cts. & Jud. Proc. 3-2A-09	
Massachusetts	$ 500,000	No	Cap does not apply in catastrophic cases as defined in statute	Mass. Gen. Laws Ch. 231, sec. 60H	
Michigan	$ 359,000	Yes - originally $280,000; figure is as of 2003	In catastrophic cases, get $500,000 adj for inflation ($641,000 as of 2003)	Mich. Comp. Laws 600.1483	
Mississippi	$ 500,000	No	No	Miss. Code Ann. 11/1/1960	
Missouri	$ 565,000	Yes - originally $350,000; figure is as of 2004	No	Mo. Rev. Stat. 538.210	
Montana	$ 250,000	No	No	Mont. Code Ann. 25-9-411	

States with caps on noneconomic damages	Cap Dollar Amount	Is cap adjusted for inflation?	Is cap otherwise adjustable?	Stat Cite	Notes
Nevada	$ 350,000	No	No	Nev. Rev. Stat. 41A.035	
North Dakota	$ 500,000	No	No	N.D. Cent. Code 32-42-02	
Ohio	$ 350,000	No	N-E damages of the greater of $250,000 or 3x economic damages up to a max of $350,000 per plaintiff or $500,000 if multiple plaintiffs. Catastrophic max may increase to $500,000 per plaintiff or $1 million for multiple plaintiffs.	Ohio Rev. Code Ann. 2323.43	
Oklahoma	$ 300,000	Yes	Only applies if there is an offer for judgment, or if care was OB or ER; cap may be lifted under some circumstances		
South Dakota	$ 500,000	No	No	S.D. Codified Laws 21-3-11	
Texas	$ 250,000	No	May recover an additional $250,000 against each involved health care institution; total limit of $500,000	Tex. Civ. Prac. & Rem. Code 74.301	
Utah	$ 400,000	Yes	No	Utah Code Ann. 78-14-7.1	
West Virginia	$ 250,000	Yes, but can't exceed 375,000	500,000 for certain catastrophic cases, adjusted for inflation but can't exceed $750,000	W. Va. Code 55-7B-8	
AVERAGE	$ 388,591				

316-North

BOB ZIEGELBAUER

STATE REPRESENTATIVE • TWENTY FIFTH ASSEMBLY DISTRICT

DATE: September 19, 2005

TO: Representative Curt Gielow, Chair
Medical Malpractice Task Force

FROM: Representative Bob Ziegelbauer

RE: Member ideas, recommendations

At our last meeting you asked for suggestions from the members of proposals to be considered for inclusion in our final package of recommendations. I would like to offer these:

I. **Insurance Market Reforms:**
Witnesses appearing before the committee frequently voiced their concerns about the current or future state of the market for malpractice insurance coverage. Given what we already know, there are some reforms we can look at right now that can increase the competitiveness and efficiency of that market.

1. Require the Injured Patients and Families Compensation Fund (IPFCF) to regularly submit to an "actuarial audit" of reserves. The most recent actuarial audit by Towers Perrins' Tillinghast consultants indicated that the IPFCF's assumptions as to future liabilities were extremely conservative, arguably resulting in excess accumulation of reserves adding to premium costs. Accumulation of excess reserves is not in the insured's or the public's interest. Regular actuarial audits will encourage the managers of the fund to keep their rates and reserves for future losses at appropriate levels.

   The recent dramatic cuts in rates by the IPFCF seem to be a reaction to that audit and Legislative Audit Bureau review.

2. Give the IPFCF the authority to create an insurance subsidiary to offer first dollar coverage in competition with private insurers if necessary.

- continued -

STATE CAPITOL: P.O. BOX 8953, MADISON, WI 53708-8953 • (608) 266-0315
TOLL FREE: 1-888-529-0025 • FAX (608)-266-0316 or (608) 282-3625 • E-MAIL: bob.ziegelbauer@legis.state.wi.us
DISTRICT: 1213 S. 8TH STREET, P.O. BOX 325, MANITOWOC, WI 54221-0325
MANITOWOC OFFICE: (920) 684-6783 • HOME: (920) 684-4362

Printed in Manitowoc Co.
PRINTED ON RECYCLED PAPER

There has been a great deal of discussion about future rates for malpractice coverage by private insurers. While many have indicated that the marketplace is operating efficiently now, both sides have expressed concern about how well it might work in the future. Allowing the IPFCF to create an independently funded subsidiary, if necessary, to offer primary coverage in competition with the other private insurers will add another competitive element that can incrementally keep them honest.

II. **Prevention of Malpractice Occurrences:**

To keep the long run cost of malpractice insurance coverage as low as possible it would seem to be in everyone's interest for us to consider strategic reforms now that might operate as preventative measures to avoid these undesirable outcomes. In 1999 there was a Legislative Council Special Study Committee that studied these issues and developed a broad consensus package of proposals dealing with regulation and discipline of Health Care Professionals.

(The Legislative Council Committee developed two bills, 1999 SB 317 and SB 318, which were never fully considered by the full Legislature during the 1999-2000 session.)

I suggest that our committee take a closer look at the Legislative Council "Report No. 14 to the 1999 Legislature" (RL 99-14) with an eye to encouraging the Legislature to use it as a beginning point to again seriously consider the kinds of preventative accountability that can reduce occurrences.

Thank you for your consideration. As always, please do not hesitate to call on me if you would like to discuss this or any other recommendations further.

###

STATE OF WISCONSIN
JOINT LEGISLATIVE COUNCIL

REPORT NO. 14 TO THE 1999 LEGISLATURE

LEGISLATION ON DISCIPLINE OF HEALTH CARE PROFESSIONALS

1999 SENATE BILL 317,	Relating to Priorities, Completion Guidelines and Notices Required for Health Care Professional Disciplinary Cases; Identification of Health Care Professionals in Possible Need of Investigation; Additional Public Members for the Medical Examining Board; Authority of the Medical Examining Board to Limit Credentials and Impose Civil Forfeitures; Reporting Requirements for Reports Submitted to the National Practitioner Data Bank; Inclusion of Health Care Professionals Who Practice Alternative Forms of Health Care on Panels of Health Care Experts Established by the Department of Regulation and Licensing; Indication of Therapeutic-Related Deaths on Certificates of Death; and Providing a Penalty
1999 SENATE BILL 318,	Relating to Making Available to the Public Information on the Education, Practice and Disciplinary History of Physicians, Requiring Rules of the Department of Health and Family Services to Include Procedures Affording Health Care Providers Opportunity to Correct Health Care Information and Granting Rule-Making Authority

Legislative Council Staff
One East Main Street, Suite 401
Madison, Wisconsin

January 21, 2000

RL 99-14

JOINT LEGISLATIVE COUNCIL
REPORT NO. 14 TO THE 1999 LEGISLATURE*

LEGISLATION ON DISCIPLINE OF HEALTH CARE PROFESSIONALS

CONTENTS

* This Report was prepared by Don Dyke, Senior Staff Attorney, Legislative Council Staff.

Also available at *www.legis.state.wi.us/lc*

PART I

KEY PROVISIONS OF LEGISLATION; COMMITTEE AND JOINT LEGISLATIVE COUNCIL VOTES

The Special Committee on Discipline of Health Care Professionals recommends the following proposals to the Joint Legislative Council for introduction in the 1999-2000 Session of the Legislature:

A. SENATE BILL 317, RELATING TO PRIORITIES, COMPLETION GUIDELINES AND NOTICES REQUIRED FOR HEALTH CARE PROFESSIONAL DISCIPLINARY CASES; IDENTIFICATION OF HEALTH CARE PROFESSIONALS IN POSSIBLE NEED OF INVESTIGATION; ADDITIONAL PUBLIC MEMBERS FOR THE MEDICAL EXAMINING BOARD; AUTHORITY OF THE MEDICAL EXAMINING BOARD TO LIMIT CREDENTIALS AND IMPOSE CIVIL FORFEITURES; REPORTING REQUIREMENTS FOR REPORTS SUBMITTED TO THE NATIONAL PRACTITIONER DATA BANK; INCLUSION OF HEALTH CARE PROFESSIONALS WHO PRACTICE ALTERNATIVE FORMS OF HEALTH CARE ON PANELS OF HEALTH CARE EXPERTS ESTABLISHED BY THE DEPARTMENT OF REGULATION AND LICENSING; INDICATION OF THERAPEUTIC-RELATED DEATHS ON CERTIFICATES OF DEATH; AND PROVIDING A PENALTY

- ***Key Provisions***

1. Requires the Department of Regulation and Licensing (DRL) to develop a system to establish the relative priority of cases involving possible unprofessional conduct on the part of a health care professional.

2. Requires the DRL to develop a system for identifying health care professionals who, even if not the subject of a specific allegation of unprofessional conduct, may nonetheless warrant further evaluation and possible investigation.

3. Requires the DRL to notify a health care professional's place of practice or employment when a formal complaint alleging unprofessional conduct by the health care professional is filed.

4. Requires the DRL to give notice to a complainant and a health care professional when: (a) a case of possible unprofessional conduct by the health care professional is closed following screening for a possible investigation; (b) a case of possible unprofessional conduct by the health care professional has been opened for investigation; and (c) a case of possible unprofessional conduct by the health care professional is closed after investigation. In addition, DRL is required to provide a copy of the notices under (b) and (c), above, to an affected patient (when the patient is not also the complainant) or the patient's family members.

5. Requires that a patient or client who has been adversely affected by a health care professional's conduct that is the subject of a state disciplinary proceeding be given opportunity to confer with the DRL's prosecuting attorney concerning the disposition of the case and the economic, physical and psychological effect of the unprofessional conduct on the patient or client.

6. Requires the DRL to establish guidelines for the timely completion of each stage of the health care professional disciplinary process.

7. Requires, if the DRL establishes panels of health care experts to review complaints against health care professionals, that DRL attempt to include on the panels health care professionals who practice alternative forms of health care to assist in evaluating cases involving alternative health care.

8. Requires, by May 1, 2001, the DRL to submit to the Legislature a report on the disciplinary process time lines which were implemented by the department as guidelines in February 1999.

9. Adds two public members to the Medical Examining Board (MEB), resulting in a 15-member MEB with five public members, nine medical doctor members and one member who is a doctor of osteopathy.

10. Authorizes the MEB to summarily limit any credential issued by the MEB pending a disciplinary hearing.

11. Authorizes the MEB to assess a forfeiture of not more than $1,000 for each violation against a credential holder found guilty of unprofessional conduct (not including negligence in treatment).

12. Creates a state requirement that reports on medical malpractice payments and on professional review actions by health care entities, which currently must be submitted to the National Practitioner Data Bank (NPDB), must also be submitted to the MEB in accordance with the time limits set forth in federal law. A person or entity who violates the state requirement is subject to a forfeiture of not more than $10,000 for each violation.

13. Provides that when a coroner or medical examiner receives a report of a death under s. 979.01, Stats., and subsequently determines that the death was therapeutic-related, as defined, the coroner or medical examiner must indicate that determination on the death certificate and forward the information to the DRL.

- ***Votes***

Senate Bill 317 consists of several proposals that were acted on separately by the Special Committee on Discipline of Health Care Professionals. The separate proposals that were combined into Senate Bill 317 and the votes on those proposals by the Special Committee on

Discipline of Health Care Professionals for recommendation to the Joint Legislative Council for introduction in the 1999-2000 Session of the Legislature are set forth below.

WLCS: 0014/1, relating to directing the DRL to establish priority discipline cases for health care professionals, factors to identify health care professionals in possible need of investigation and time lines for the health care professional disciplinary process and requiring notice to health care professionals and their places of employment and to complainants, patients and clients in connection with the disciplinary process (as amended): Ayes, 11 (Sens. Huelsman; Reps. Underheim, Urban and Wasserman; and Public Members Clifford, Freil, Newcomer, Noack, Roberts, Schultz and Schulz); Noes, 0; and Absent, 5 (Sen. Risser; Reps. Cullen and Seratti; and Public Members Rosenberg and Wolverton).

WLCS: 0060/2 relating to changing the composition of the MEB: Ayes, 9 (Sen. Huelsman; Reps. Cullen, Underheim and Urban; and Public Members Clifford, Freil, Noack, Schultz and Schulz); Noes, 3 (Rep. Wasserman; and Public Members Newcomer and Roberts); and Absent, 4 (Sen. Risser; Rep. Seratti; and Public Members Rosenberg and Wolverton).

WLCS: 0067/1, relating to authorizing the MEB to summarily limit a credential granted by the board: Ayes, 9 (Sens. Huelsman and Risser; Rep. Wasserman; and Public Members Newcomer, Noack, Rosenberg, Schultz, Schulz and Wolverton); Noes, 0; and Absent, 7 (Reps. Underheim, Cullen, Seratti and Urban; and Public Members Clifford, Freil and Roberts).

WLCS: 0068/1, relating to authorizing the MEB to impose a civil forfeiture in certain cases of unprofessional conduct: Ayes, 13 (Sen. Huelsman; Reps. Underheim, Cullen, Seratti, Urban and Wasserman; and Public Members Clifford, Freil, Newcomer, Noack, Roberts, Schultz and Schulz); Noes, 0; and Absent, 3 (Sen. Risser; and Public Members Rosenberg and Wolverton).

WLCS: 0101/1, relating to requiring reports which must be submitted to the NPDB to be submitted to the MEB and providing a penalty (as amended): Ayes, 13 (Sen. Huelsman; Reps. Underheim, Cullen, Seratti, Urban and Wasserman; and Public Members Clifford, Freil, Newcomer, Noack, Roberts, Schultz and Schulz); Noes, 0; and Absent, 3 (Sen. Risser; and Public Members Rosenberg and Wolverton).

WLCS: 0104/P1, relating to including health care professionals who practice alternative forms of health care in panels of health care experts established by the DRL: Ayes, 10 (Sen. Huelsman; Reps. Underheim, Cullen and Seratti; and Public Members Clifford, Freil, Noack, Roberts, Schultz and Schulz); Noes, 2 (Reps. Urban and Wasserman); and Absent, 4 (Sen. Risser; and Public Members Newcomer, Rosenberg and Wolverton).

WLCS: 0021/2, relating to requiring coroners and medical examiners to indicate on certificates of death when a death is therapeutic-related and to provide this information to the DRL: Ayes, 13 (Sen. Huelsman, Reps. Underheim, Cullen, Seratti, Urban and Wasserman; and Public Members Clifford, Freil, Newcomer, Noack, Roberts, Schultz and Schulz); Noes, 0; and Absent, 3 (Sen. Risser; and Public Members Rosenberg and Wolverton).

At its September 23, 1999 meeting, the Joint Legislative Council voted to introduce 1999 Senate Bill 317 (WLCS: 0147/1) by a vote of Ayes, 15 (Reps. Kelso, Bock, Foti, Freese, Huber, Jensen, Schneider, Seratti and Stone; and Sens. Risser, Burke, Cowles, Erpenbach, Grobschmidt and Robson); Noes, 0; and Absent, 7 (Reps. Gard and Krug; and Sens. Chvala, Ellis, George, Rosenzweig and Zien).

B. SENATE BILL 318, RELATING TO MAKING AVAILABLE TO THE PUBLIC INFORMATION ON THE EDUCATION, PRACTICE AND DISCIPLINARY HISTORY OF PHYSICIANS, REQUIRING RULES OF THE DEPARTMENT OF HEALTH AND FAMILY SERVICES TO INCLUDE PROCEDURES AFFORDING HEALTH CARE PROVIDERS OPPORTUNITY TO CORRECT HEALTH CARE INFORMATION AND GRANTING RULE-MAKING AUTHORITY

- ***Key Provisions***

1. Directs the MEB to make available for dissemination to the public, in a format established by the board, specified information concerning a physician's education, practice, malpractice history, criminal history and disciplinary history. The costs incurred by the DRL in connection with making physician information available to the public is funded by a surcharge on the license renewal fee paid biennially by physicians licensed in this state.

2. Requires administrative rules of the Department of Health and Family Services (DHFS) to include procedures affording health care providers the opportunity to correct health care information collected under ch. 153, Stats.

- ***Votes***

Senate Bill 318 combines two drafts separately considered by the Special Committee on Discipline of Health Care Professionals. One of the drafts, WLCS: 0015/1, was voted on by the Special Committee at its April 20, 1999 meeting; subsequent to that meeting, two remaining issues related to the draft were resolved by the adoption of two amendments by mail ballot. The other draft included in WLCS: 0015/2 is WLCS: 0034/P1. The votes by the Special Committee on Discipline of Health Care Professionals to recommend the two drafts that were combined to create WLCS: 0015/2 to the Joint Legislative Council for introduction in the 1999-2000 Legislature are set forth below.

WLCS: 0034/P1, relating to procedures to provide an opportunity to correct certain health care information and providing rule-making authority: Ayes, 10 (Sens. Huelsman and Risser; Reps. Urban and Wasserman; and Public Members Newcomer, Noack, Rosenberg, Schultz, Schulz and Wolverton); Noes, 0; and Absent, 6 (Reps. Underheim, Cullen and Seratti; and Public Members Clifford, Freil and Roberts).

WLCS: 0015/1, relating to making available to the public certain information on the education, practice and disciplinary history of physicians and granting rule-making authority (as amended): Ayes, 13 (Sen. Huelsman; Reps. Underheim, Cullen, Seratti, Urban and Wasserman;

and Public Members Clifford, Freil, Newcomer, Noack, Roberts, Schultz and Schulz); Noes, 0; and Absent, 3 (Sen. Risser; and Public Members Rosenberg and Wolverton).

At its September 23, 1999 meeting, the Joint Legislative Council voted to introduce 1999 Senate Bill 318 (WLCS: 0015/2) by a vote of Ayes, 17 (Reps. Kelso, Bock, Foti, Freese, Gard, Huber, Jensen, Seratti and Stone; and Sens. Risser, Burke, Chvala, Cowles, Grobschmidt, Robson, Rosenzweig and Zien); Noes, 2 (Rep. Schneider and Sen. Erpenbach); and Absent, 3 (Rep. Krug; and Sens. Ellis and George).

PART II

COMMITTEE ACTIVITY

A. ASSIGNMENT

The Joint Legislative Council established the Special Committee and appointed the chairperson by a June 24, 1998 mail ballot. The Special Committee was directed to study procedures for imposition of discipline for alleged cases of patient neglect or unprofessional conduct by health care-related examining boards and affiliated credentialing boards identified by the Special Committee, for the purpose of ensuring that such procedures are effective, fair and consistent.

The membership of the Special Committee, appointed by a September 4, 1998 mail ballot, consisted of two Senators, five Representatives and nine Public Members.

A membership list of the Joint Legislative Council is included as **Appendix 1**. A list of the Committee membership is included as **Appendix 2.**

B. SUMMARY OF MEETINGS

The Special Committee held seven meetings at the State Capitol in Madison on the following dates:

October 8, 1998
November 18, 1998
December 18, 1998
January 20, 1999
February 9, 1999
March 11, 1999
April 20, 1999

At the October 8, 1998 meeting, the Special Committee received testimony from Marlene Cummings, Secretary, DRL; Dr. Walter R. Schwartz, Chairperson, MEB; Mark Adams, Corporate Counsel, and John La Bissioniere, Peer Review Consultant, State Medical Society of Wisconsin (SMS). Secretary Cummings described the DRL complaint handling process for cases of unprofessional conduct. She described recent DRL efforts to strengthen and expedite the complaint handling process and provided data concerning complaints of unprofessional conduct and the disposition of those complaints. Dr. Schwartz outlined the current membership of the MEB and discussed MEB involvement in cases of unprofessional conduct by credential holders. Dr. Schwartz discussed common types of cases of unprofessional conduct involving physicians and typical discipline. Mr. Adams described past initiatives by the SMS regarding physician discipline. He also described the SMS Commission on Mediation and Peer Review, which reviews complaints against physicians and recommends solutions. Mr. La Bissioniere described the Statewide Physician Health Program of the SMS, which assists physicians in dealing with alcohol and chemical dependency problems.

The Special Committee also briefly reviewed a staff brief on discipline of health care professionals and a staff memorandum concerning recommendations of the DRL Ad Hoc Enforcement Advisory Committee concerning time lines for disciplinary cases.

At the November 18, 1998 meeting, the Committee received testimony from Richard Roberts, M.D., Department of Family Medicine, University of Wisconsin (UW)-Madison Medical School; Steve Baker, M.D., Medical Director, Wendy Potochnik, Director of Quality Management and Candice Freil, Vice President, Health Services, PrimeCare Health Plan, Milwaukee; Richard Hendricks, M.D., Medical Director, St. Mary's Hospital, Madison; Barbara Rudolph, Ph.D., Director, Bureau of Health Care Information, DHFS; Tom Meyer, M.D., and George Mejicano, M.D., UW Office of Continuing Medical Education Assessment and Remedial Continuing Education, Madison; and Don Prachthauser, Attorney, Murphy, Gillick, Wicht and Prachthauser, Milwaukee, and President, Wisconsin Academy of Trial Lawyers. In his presentation, Dr. Roberts discussed what is happening today in the health care system, provided an example of the various levels of quality review of an individual physician and discussed the issue of competence in connection with health care. Dr. Baker and Ms. Potochnik addressed physician monitoring in the health plan setting. Dr. Hendricks addressed the role of hospitals in physician reviews. Ms. Rudolph addressed the Bureau of Health Care Information's plans concerning an annual guide to assist consumers in selecting health care providers and health care plans. Dr. Meyer discussed the evolution of the program offered by the UW Office of Continuing Medical Education to assess the needs of individual physicians and to educate physicians who are in need of training in a specific area of practice. Dr. Mejicano provided information on the number of assessment programs, profiles of physicians who are referred to the programs and assessment tools used by the programs. He also discussed the assessment and remediation processes and the costs of those processes. Mr. Prachthauser addressed the issue of physician discipline for unprofessional conduct from the perspective of an attorney who has represented patients with malpractice claims against physicians and other health care providers.

At the December 18, 1998 meeting, the Special Committee received testimony from Don Rittel, Administrative Law Judge, DRL; Attorney Michael P. Malone, Hinshaw and Culbertson, Milwaukee; and Dr. Jeffrey Jentzen, Milwaukee County Medical Examiner. Mr. Rittel discussed his functions in DRL: (1) providing legal counsel services to various professional boards housed in the department; and (2) functioning as an administrative law judge in formal disciplinary proceedings. He focused his remarks on his role as an administrative law judge, including disciplinary proceedings involving physicians. Mr. Malone addressed the physician disciplinary process from the perspective of an attorney who has represented a number of physicians before the MEB since the early 1980s. Dr. Jentzen described the current role of coroners and medical examiners in reporting sudden or unexplained deaths in a health care setting and determining the cause and manner of death. He commented on the desirability of including an option for indicating therapeutic-related deaths on Wisconsin's death certificate. Committee members engaged in an initial discussion of possible recommendations from the Committee to improve the health care professional disciplinary process.

At the January 20, 1999 meeting, the Special Committee discussed issues and possible recommendations relating to the purpose of the MEB, the definition of "unprofessional conduct" on the part of physicians; required reporting in records provided to the MEB; a Massachusett's

law on individual physician profiles provided over the Internet; issues relating to the MEB disciplinary procedure; whether a provision should be included on the Wisconsin death certificate for indicating therapeutic-related deaths; and DRL biennial budget requests of interest.

At the February 9, 1999 meeting of the Special Committee, the Special Committee reviewed drafts relating to: disclosure of certain health care services review records and information to examining or licensing boards or agencies; the purpose of the MEB, directing the MEB to establish priorities, factors to identify physicians in possible need of investigation, time lines for the disciplinary process and to give notice to physicians and their places of employment in connection with the disciplinary process; indicating therapeutic misadventures on certificates of death and providing information to the MEB; making available to the public certain information on the education, practice and disciplinary history of physicians; procedures providing opportunity to correct certain health care information; information to be provided by credential holders to the DRL; and the practice of alternative medicine by a physician.

At the March 11, 1999 meeting of the Special Committee, the Committee considered several previously considered drafts, including revised versions of some of those drafts. In addition, the Special Committee considered drafts relating to: changing the composition of the MEB; authorizing the MEB to summarily limit a credential granted by the board; and authorizing the MEB to impose a civil forfeiture in certain cases of unprofessional conduct. The Committee approved WLCS: 0034/P1, relating to procedures providing opportunity to correct certain health care information, and WLCS: 0067/1, relating to authorizing the MEB to summarily limit a credential granted by the board. The Committee voted to send to the Joint Committee on Finance, on behalf of the Special Committee, a letter expressing the Committee's support for two items contained in the Governor's Biennial Budget Bill (1999 Assembly Bill 133) providing appropriations to DRL for two items of particular interest to the Special Committee. That letter, included in **Appendix 3**, was sent to the Joint Committee on Finance, which subsequently approved the budget items.

At the Special Committee's April 20, 1999 meeting, the Committee heard from four members of the MEB: Public Members Virginia Scott Heinemann and Wanda A. Roever and Drs. Darold A. Treffert and Glenn Hoberg, Chair. The MEB members discussed the respective roles of public and professional members on the MEB. The Special Committee then voted on a variety of draft legislation and approved the following drafts: WLCS: 0014/1 (as amended), relating to directing DRL to establish priority discipline cases for health care professionals, factors to identify health care professionals in possible need of investigation, and time lines for the health care professional disciplinary process and requiring notice to health care professionals and their places of employment and to complainants, patients and clients in connection with the disciplinary process; WLCS: 0015/1 (as amended), relating to making available to the public certain information on the education, practice and disciplinary history of physicians. [The Committee set aside two issues relating to WLCS: 0015/1 for mail ballot. By mail ballot dated May 14, 1999, the Special Committee approved two amendments to WLCS: 0015/1.]; WLCS: 0021/2, relating to requiring coroners and medical examiners to indicate on certificates of death when a death is therapeutic-related and to provide this information to the DRL; WLCS: 0068/1, relating to authorizing the MEB to impose a civil forfeiture in certain cases of unprofessional conduct; WLCS: 0101/1, relating to requiring reports which must be submitted to the NPDB to

be submitted to the MEB; and WLCS: 0104/P1, relating to including health care professionals who practice alternative forms of health care on panels of health care experts established by DRL. At the request of Chairperson Huelsman, the Special Committee agreed to permit Chairperson Huelsman to package the Special Committee's recommendations into one or more drafts for consideration by the Joint Legislative Council.

C. STAFF MATERIALS AND OTHER MATERIALS

Appendix 4 lists all of the materials received by the Special Committee on Discipline of Health Care Professionals. In addition to these listed materials, Legislative Council Staff prepared several bill drafts for the Special Committee and a summary of each of the Special Committee's meetings.

PART III

BACKGROUND; DESCRIPTION OF BILLS

This Part of the Report provides background information on, and a description of, the bills introduced by the Joint Legislative Council on the recommendation of the Special Committee on Discipline of Health Care Professionals.

During the last three decades, the issue of discipline of physicians by the MEB and DRL has received considerable legislative attention, often in connection with consideration of medical malpractice issues. For example, in the 1975 Legislative Session, ch. 448, Stats., relating to licensure and discipline of physicians, was repealed and recreated in order to strengthen and modernize the chapter. [Ch. 383, Laws of 1975.] In that same session, significant legislation relating to health care liability and patients compensation was enacted. [Ch. 37, Laws of 1975.] In the 1985 Legislative Session, significant legislation addressing patients compensation and medical malpractice also included provisions on physician discipline. [1985 Wisconsin Act 340.] In the 1997-98 Legislative Session, the Legislature enacted 1997 Wisconsin Act 311, relating to the physician discipline process, and also considered medical malpractice issues in connection with limits on wrongful death actions. [1997 Wisconsin Act 89.]

While 1997 Wisconsin Act 311 addressed many issues in the physician discipline process, there was legislative interest in determining whether any remaining issues should be addressed. In addition, interest was expressed in reviewing issues that might arise in the discipline process for other health care professionals. The Special Committee on Discipline of Health Care Professionals focused its attention and deliberations on the physician discipline process; however, several of its recommendations also apply to the health care professional discipline process generally, in those areas where the Special Committee concluded that public policy, including consistency of treatment, warranted application to other health care professionals.

A. 1999 SENATE BILL 317

1. Definition of "Health Care Professional"

Several provisions of Senate Bill 317 apply to the discipline processes for "health care professionals." Included in the definition of "health care professional" under the draft are: acupuncturists; audiologists; chiropractors; dental hygienists; dentists; dieticians; hearing instrument specialists; licensed practical nurses; registered nurses; nurse midwives; occupational therapists; occupational therapy assistants; optometrists; pharmacists; physical therapists; physicians; physician assistants; podiatrists; private practice school psychologists; psychologists; respiratory care practitioners; and speech-language pathologists.

2. Establishment of Priority Discipline Cases

a. Background

Currently, the DRL effectively establishes priorities in health care professional discipline cases through the enforcement process, including utilization of complaint handling teams and periodic screening of possible discipline cases. The Legislature, in 1997 Wisconsin Act 311, effectively established that physician discipline cases involving the death of a patient be given priority by establishing time deadlines for initiating an investigation in such cases.

The Special Committee determined that continuation of the practice of establishing priority of cases involving possible unprofessional conduct on the part of health care professionals is warranted and determined that special emphasis should be given to cases involving the death of a patient or client, serious injury to a patient or client, substantial damages incurred by a patient or client or sexual abuse of a patient or client.

b. Description of Bill

Senate Bill 317 requires the DRL to develop a system to establish the relative priority of cases involving possible unprofessional conduct on the part of a health care professional. The prioritization system is to give highest priority to cases of unprofessional conduct that have the greatest potential to adversely affect public health, safety and welfare. In establishing the priorities, the DRL is to give particular consideration to cases of unprofessional conduct that may involve the death of a patient or client, serious injury to a patient or client, substantial damages incurred by a patient or client or sexual abuse of a patient or client. The priority system is to be used to determine which cases receive priority of consideration and resources in order for the DRL and health care credentialing authorities to most effectively protect the public health, safety and welfare.

3. Establishment of System for Identifying Health Care Professionals Who May Warrant Possible Investigation

a. Background

Among the resources reviewed by the Special Committee was *Evaluation of Quality of Care and Maintenance of Competence*, Federation of State Medical Boards of the United States, Inc., 1998. The report contains a series of recommendations by the Federation's Special Committee on the Evaluation of Quality of Care and Maintenance of Competence, which were adopted as policy by the house of delegates of the federation in May 1998.

One of the recommendations included in the report suggests that state medical boards develop a system of markers to identify licensees warranting evaluation. Narrative comments to the recommendation note that historically, the disciplinary function of state medical boards may be characterized as reactive. It is suggested that measures to prevent, in contrast to only reacting to, breaches of professional conduct and to improve physician practice will greatly enhance public protection. The development of a system of markers is one means to identify physicians,

before a case of unprofessional conduct arises, who may be failing to maintain acceptable standards in one or more areas of professional physician practice as well as to identify opportunities to improve physician practice.

The Special Committee concluded that the rationale for developing a system of markers for identifying physicians who may need additional scrutiny applies as well to other health care professionals.

b. Description of Bill

Senate Bill 317 requires the DRL to develop a system for identifying health care professionals who, even if not the subject of a specific allegation of, or specific information relating to, unprofessional conduct, may warrant further evaluation and possible investigation.

4. Notice to Health Care Professionals, Complainants and Patients Concerning Disciplinary Cases

a. Background

In reviewing the physician disciplinary process, members of the Special Committee urged that both physicians and patients be informed of the early stages of the disciplinary process without adversely affecting DRL's investigative efforts. The Special Committee learned that current practice of DRL is to give physicians notice that a case of possible unprofessional conduct has been opened for investigation, but that the DRL may delay giving notice if the investigation will be adversely affected. It is not current practice to notify complainants or patients of the early stages of the disciplinary process. The Special Committee concluded that providing notice to credential holders, complainants and patients and clients of the early stages of a disciplinary case against a health care professional is desirable and will contribute to the fairness of, and confidence in, the disciplinary process. The Committee concluded, however, that no purpose would be served in notifying patients and clients who are not also complainants that a case has been closed following screening for possible investigation.

b. Description of Bill

Senate Bill 317 requires the DRL, within 30 days after the occurrence of the event requiring notice, to notify a health care professional in writing: (1) when a case of possible unprofessional conduct by the health care professional is closed following screening for a possible investigation; (2) when a case of possible unprofessional conduct by the health care professional has been opened for investigation; and (3) when a case of possible unprofessional conduct by the health care professional is closed after an investigation. These notice requirements address only the early stages of the disciplinary process because it is assumed that if a disciplinary case continues after an investigation is completed, the health care professional will be well aware of the course of proceedings from that point on. These notice requirements generally reflect current DRL practice.

The bill also requires the DRL to make a reasonable attempt to provide the complainant in a disciplinary case with a copy of each notice made under the requirement described above that relates to a disciplinary proceeding requested by the complainant. If the case involves conduct adversely affecting a patient or client of the health care professional and the patient or client is not a complainant, the DRL is required to make a reasonable attempt to: (1) provide the patient or client with a copy of a notice when a case of possible unprofessional conduct has been opened for investigation and when a case is closed after an investigation; or (2) provide the spouse, child, sibling, parent or legal guardian of the patient or client with a copy of such notice. The notice requirements for complainants and patients and clients are new.

5. Notice of Pending Complaint to a Health Care Professional's Place of Practice

a. Background

Many health care professionals practice in multiple settings. Thus, many or most of a health care professional's places of practice may be unaware of a pending disciplinary action against the health care professional even after a formal complaint is filed. The Special Committee concluded that upon the filing of a formal complaint alleging unprofessional conduct on the part of a health care professional, it is desirable for the DRL to notify all places of a health care professional's practice or employment to alert them of the pending disciplinary action, providing them opportunity to determine if any action on their part might be desirable.

b. Description of Bill

Senate Bill 317 requires the DRL, within 30 days after a formal complaint alleging unprofessional conduct by a health care professional is filed, to send written notice that a complaint has been filed to: (1) each hospital where the health care professional has hospital staff privileges; (2) each managed care plan for which the health care professional is a participating provider; and (3) each employer, not included under (1) or (2), above, who employs the health care professional to practice the health care profession for which the health care professional is credentialed.

The bill expressly requires a health care professional, if requested by the DRL, to provide information necessary for the department to comply with the notice requirements.

6. Opportunity for Patients and Clients to Confer Concerning Discipline

a. Background

Some members of the Special Committee contended that a means of enhancing public confidence in the health care professional disciplinary system is to increase public involvement in that process. More public involvement may increase understanding of the process and improve public perception of the process. Further, involvement may increase public scrutiny and result in more timely completion of the process. The Special Committee concluded that it is desirable to require that a patient or client of a health care professional who has been adversely

affected by conduct of the health care professional that is the subject of a disciplinary proceeding be given the opportunity to confer with the DRL's prosecuting attorney concerning the disposition of the case and the economic, physical and psychological effects of the unprofessional conduct on the patient or client.

b. Description of Bill

Senate Bill 317 provides that, following an investigation of possible unprofessional conduct on the part of a health care professional and before a disciplinary action may be negotiated or imposed against the health care professional, a patient, as defined under the bill, must be provided an opportunity to confer with the DRL's prosecuting attorney concerning the disposition of the case and the economic, physical and psychological effect of the unprofessional conduct on the patient. The bill provides that the prosecuting attorney may confer with a patient in person or by telephone or, if the patient agrees, by any other method. It is expressly provided that the duty to confer does not limit the authority or obligation of the prosecuting attorney to exercise his or her discretion concerning the handling of a case of unprofessional conduct against the health care provider.

7. Establishment of Guidelines for Timely Completion of Disciplinary Process; Report to Legislature

a. Background

The Special Committee was apprised of and was supportive of recommendations of the DRL Ad Hoc Enforcement Advisory Committee that established specific time lines for processing disciplinary cases, once a complaint is received by the DRL Division of Enforcement. The DRL adopted the recommended time lines as department policy in February 1999. The Special Committee concluded that the establishment of time guidelines for the health care professional disciplinary process is critical for the efficient and timely completion of discipline cases and concluded that statutorily requiring the establishment of time guidelines is desirable.

b. Description of Bill

Senate Bill 317 requires the DRL to establish guidelines for the timely completion of each stage of the health care professional disciplinary process. Under the bill, the guidelines may account for the type and complexity of the case and must promote the fair and efficient processing of cases of unprofessional conduct. It is expressly provided that the guidelines are for administrative purposes, to permit the department to monitor the progress of cases and the performance of personnel handling the cases.

In addition, the bill requires that, no later than May 1, 2001, the DRL submit to the Legislature a report on the disciplinary process time lines which were implemented by the department as guidelines in February 1999. The report is required to address compliance with and enforcement of the guidelines and the effect of the guidelines on the fairness and efficiency of the disciplinary process.

8. Inclusion of Alternative Health Care Practitioners on Panels of Experts

a. Background

During its deliberations, the Special Committee discussed the issue of alternative health care as it relates to the health care professional disciplinary process. While several options were discussed by the Committee, the only proposal in this regard voted on by the Committee was to place alternative health care practitioners on any panels of experts that the DRL establishes for use on a consulting basis by health care credentialing authorities. It was suggested that including alternative health care professionals on expert panels will enhance the fairness and expertise of the panels in dealing with alternative health care issues.

b. Description of Bill

Senate Bill 317 provides that if the DRL establishes panels of health care experts to be used on a consulting basis by health care credentialing authorities, the DRL must attempt to include health care professionals who practice alternative forms of health care on the panels. The alternative health care practitioners would assist in evaluating cases involving a health care professional alleged to have practiced health care in an unprofessional or negligent manner through: (1) the use of alternative forms of health care; (2) the referral to an alternative health care provider; or (3) the prescribing of alternative medical treatment. A health care professional who practices alternative health care and who participates on a panel must be of the same profession as the health care professionals regulated by the health care credentialing authority utilizing the panel.

9. Composition of MEB

a. Background

In reviewing the current membership of the MEB (nine licensed doctors of medicine, one licensed doctor of osteopathy and three public members), some members of the Special Committee expressed concern whether the three public members might be unduly influenced by the 10 professional members. The Special Committee considered proposals to revise the membership of the MEB, including replacing two of the current professional members with two public members. At its last meeting, the Special Committee heard from representatives of the MEB, including two current public members. It was the consensus of the MEB representatives that professional expertise on the MEB is vital, that public members are not unduly influenced by professional members and that removing any of the current professional members is undesirable; however, there was no objection to increasing the number of public members on the MEB.

b. Description of Bill

Senate Bill 317 adds two public members to the MEB, resulting in a 15-member MEB with five public members, nine medical doctor members and one member who is a doctor of osteopathy. The new members will serve four-year terms.

10. Summary Limitation of Credential Issued by MEB

a. Background

Current law authorizes the MEB to summarily suspend any credential granted by it, pending a disciplinary hearing, for a period not to exceed 30 days, when the board has in its possession evidence establishing probable cause to believe: (1) that the credential holder has violated the provisions of ch. 448, Stats.; and (2) that it is necessary to suspend the credential to protect the public health, safety or welfare. [s. 448.02 (4), Stats.] The credential holder must be granted an opportunity to be heard during the process for determination if probable cause for suspension exists. The MEB is authorized to designate any of its officers to exercise the suspension authority but suspension by an officer may not exceed 72 hours. If a credential has been suspended pending hearing, the MEB may, while the hearing is in progress, extend the initial 30-day period of suspension for an additional 30 days. If the credential holder has caused a delay in the hearing process, the MEB may subsequently suspend the credential from the time the hearing is commenced until a final decision is issued, or may delegate that authority to the administrative law judge.

It was pointed out to the Special Committee that the current authority of the MEB to summarily suspend any credential granted by the MEB, while limited as to duration, is a suspension of the entire credential, i.e., no limited summary suspension of a credential is authorized. It was suggested that it would be a useful enforcement tool for the MEB to be able to summarily limit any credential issued by the MEB; thus, for example, a physician could be restricted from practicing in a certain area of practice, pending a disciplinary hearing, but be permitted to practice in nonrestricted areas. The ability to summarily limit a credential may result in increased fairness to credential holders and increased use of the summary suspension procedure by the MEB.

b. Description of Bill

Senate Bill 317 adds to the current summary suspension authority and procedure the authority to summarily limit any credential issued by the MEB.

11. Authority of MEB to Impose a Forfeiture for Certain Unprofessional Conduct

a. Background

It was suggested to the Special Committee that an additional enforcement tool that might be useful for the MEB is a civil forfeiture against a credential holder found guilty of unprofessional conduct. It was noted that certain other health care professional credentialing authorities currently have forfeiture authority, such as the Dentistry Examining Board and the Pharmacy Examining Board. [ss. 447.07 (7) and 450.10 (2), Stats.] In discussing the issue, the Special Committee concluded that exposure to malpractice awards and the cost of defending malpractice actions make unnecessary a civil forfeiture for unprofessional conduct that constitutes negligence in treatment.

b. Description of Bill

Senate Bill 317 gives the MEB authority to assess a forfeiture of not more than $1,000 for each violation against a credential holder found guilty of unprofessional conduct; the authority to assess the civil forfeiture does not extend to a violation that constitutes negligence in treatment.

12. Reports to MEB of Reports to NPDB

a. Background

The Special Committee extensively discussed the nature and frequency of information received by the MEB concerning actions taken against credential holders in other contexts that may indicate possible unprofessional conduct on the part of the credential holder. Both state and federal law were reviewed in this regard. The Special Committee learned that federal law contains extensive reporting requirements on actions against or concerning physicians and that, under federal law, the reports must also be made to the MEB. The Special Committee learned that recent evidence suggests that compliance with the federal reporting requirements is low.

The Special Committee concluded that, rather than requiring additional or duplicative reports at the state level, a state penalty should be created for failure to submit reports to the MEB as required under federal law.

Under current law, the federal Health Care Quality Improvement Act [42 U.S.C. ss. 11111 to 11152] requires certain entities to report information on physicians to the NPDB. Specifically, 42 U.S.C. s. 11131 requires entities (including insurance companies) which make payment under an insurance policy or in settlement of a malpractice action or claim to report information on the payment and the circumstances of the payment to the NPDB. Boards of medical examiners (in this state, the MEB) must report actions which suspend, revoke or otherwise restrict a physician's license or censure, reprimand or place a physician on probation; physician surrender of a license also must be reported. [42 U.S.C. s. 11132.] In addition, under 42 U.S.C. s. 11133, health care entities (which include hospitals, health maintenance organizations, group medical practices and professional societies) must report to the NPDB: professional review actions which adversely affect the clinical privileges of a physician for longer than 30 days; the surrender of a physician's clinical privileges while the physician is under investigation or in return for not investigating the physician; or a professional review action which restricts membership in a professional society.

Federal regulations require the information on malpractice payments to be reported to the NPDB within 30 days of a payment, and simultaneously to the board of medical examiners. [45 C.F.R. s. 60.5 (a).] A payor is subject to a fine of up to $10,000 for each nonreported payment.

Federal regulations require health care entities to report adverse actions to the board of medical examiners within 15 days (which, in turn, has 15 days to forward the report to the NPDB). [45 C.F.R. s. 60.5 (c).] The penalty for not complying with these reporting requirements is a loss of the immunity protections under the Health Care Quality Improvement Act.

b. Description of Bill

Senate Bill 317 creates a state requirement that reports on medical malpractice payments and professional review actions by health care entities that under federal law are submitted to the NPDB must be submitted to the MEB in accordance with the time limits set forth under federal law. An individual or entity who violates this requirement is subject to a forfeiture of not more than $10,000 for each violation.

13. Indication of Certain Therapeutic-Related Deaths on Death Certificate

a. Background

The Special Committee reviewed the functions and duties of coroners and medical examiners. It was suggested by the Milwaukee County medical examiner that it might be useful, for disciplinary purposes, that the MEB and other state health care credentialing authorities be notified when a coroner or medical examiner determines that a death was therapeutic-related. Currently, there is no provision or requirement for a coroner or medical examiner to indicate a therapeutic-related death on a death certificate.

Under current s. 69.18 (2) (d) 1., Stats., if a death is the subject of a coroner's or medical examiner's determination under s. 979.01 or 979.03, Stats., the coroner or medical examiner or a physician supervised by a coroner or medical examiner in the county where the event which caused the death occurred is required to complete and sign the medical certification part of the death certificate and mail the death certificate within five days after the pronouncement of death or present the certificate to the person responsible for filing the death certificate within six days after the pronouncement of death.

Further, s. 69.18 (2) (f), Stats., provides that a person signing a medical certification part of the death certificate must describe, in detail, on a form prescribed by the state registrar, the cause of death; show the duration of each cause and the sequence of each cause if the cause of death was multiple; and, if the cause was disease, the evolution of the disease.

b. Description of Bill

Senate Bill 317 provides that when a coroner or medical examiner receives a report of a death under s. 979.01, Stats., and subsequently determines that the death was therapeutic-related, the coroner or medical examiner must indicate this determination on the death certificate. The bill creates a definition of "therapeutic-related death" based on the definition contained in the instruction manual on completing the death certificate published by the State of Wisconsin. The definition includes three types of therapeutic-related deaths: death resulting from complications of surgery, prescription drug use or other medical procedures performed or given for disease conditions; death resulting from complications of surgery, drug use or medical procedures performed or given for traumatic conditions; or death resulting from "therapeutic misadventures," where medical procedures were done incorrectly or drugs were given in error. The bill requires the state registrar to revise the death certificate to include a space in which determinations of therapeutic-related deaths may be recorded. Finally, the bill requires the coroner or medical

examiner who determines that a death is therapeutic-related to forward this information to the DRL.

Under the bill, these provisions first take effect on the first day of the sixth month beginning after publication.

B. SENATE BILL 318

1. Background

Early in its deliberations, the Special Committee learned that the DRL intends to include on its website information on completed disciplinary actions against physicians. In addition, the Special Committee heard from the Bureau of Health Care Information, DHFS, regarding DHFS's efforts to implement that portion of 1997 Wisconsin Act 231 which requires DHFS to prepare an annual consumer guide to assist consumers in selecting health care providers and health care plans. In response, members of the Special Committee expressed interest in determining whether more legislative direction concerning information on individual physicians provided by the state for the public should be considered.

The Special Committee reviewed a Massachusetts law that directs the Massachusetts Board of Registration in Medicine (the Massachusetts counterpart to the MEB) to collect certain information to create individual profiles on physicians in a format created by the board for dissemination to the public. [Annotated Laws of Massachusetts, General Laws, ch. 112, s. 5 (1998 Cumulative Supplement).] That directive resulted in an initiative known as "Massachusetts Physician Profiles." Under that initiative, information on over 27,000 individual physicians licensed to practice medicine in Massachusetts is available to the public from the Massachusetts Board of Registration in Medicine home page. The Committee also received general information on recent legislative activity in connection with state regulatory boards for health care providers educating consumers in obtaining information necessary to make decisions about health care practitioners.

The Special Committee concluded that it is desirable to have information on individual physicians available at one source for the convenience and utility it affords the public. Further, because the DRL intends to provide information on its website on state disciplinary actions against physicians, inclusion of more comprehensive information will better balance the information provided by the state. Providing information on individual physicians should enhance the public's ability to choose physicians and the public's confidence in physicians.

2. Description of Bill

Senate Bill 318: (a) directs the MEB to make available for dissemination to the public, in a format established by the MEB, specified information concerning a physician's education, practice, malpractice history, criminal history and disciplinary history; and (b) requires administrative rules of DHFS to include procedures affording health care providers the opportunity to

correct health care information collected under ch. 153, Stats. If enacted, Senate Bill 318 would take effect on the 1st day of the 12th month beginning after its publication.

The provisions of the bill relating to information on individual physicians are based on the Massachusetts law cited above. The bill requires the following information on physicians to be made available to the public:

a. Names of medical schools attended and dates of graduation; graduate medical education; and eligibility status for any specialty board certification and certification by any specialty board.

b. Number of years in practice or first year admitted to practice; location of primary practice setting; identification of any translating services that may be available at the primary practice location; names of hospitals where the physician has privileges; indication whether the physician participates in the Medical Assistance program and in the Medicare program; and, optionally, education appointments and indications whether the physician has had a responsibility for graduate medical education within the preceding 10 years.

c. A description of any felony conviction within the preceding 10 years.

d. A description of any final board disciplinary action taken within the preceding 10 years, including action taken by a licensing board of another jurisdiction that has been reported to the MEB.

e. A description of Medical Assistance program decertification or suspension within the preceding 10 years that is required to be reported to the MEB under s. 49.45 (2) (a) 12r., Stats. Under that section, DHFS is required to report any Medical Assistance decertification or suspension if the grounds include fraud or a quality of care issue.

f. A description of any loss or reduction of hospital staff privileges or resignations from hospital staff within the preceding 10 years that is required to be reported to the MEB under s. 50.36 (3) (b) and (c), Stats. Under that section, hospitals are required to report both a loss or reduction of hospital staff privileges or resignation from hospital staff due to reasons that include the quality of or ability to practice and a loss or reduction of hospital staff privileges or resignation from hospital staff for 30 days or more as a result of peer investigation for reasons that do not include the quality of or ability to practice.

g. A description of any disciplinary action taken by a health maintenance organization, limited service health organization, preferred provider plan or managed care plan within the preceding 10 years that is required to be reported to the MEB under s. 609.17, Stats. Under the bill, if the MEB determines that a reported action is the result of a business or economic decision and does not involve conduct by the physician that appears to relate to possible unprofessional conduct or negligence in treatment, the board may omit that action from the information made available to the public.

h. A description of any action taken by an insurer against a physician within the preceding 10 years that is required to be reported to the MEB under s. 632.715, Stats. Under that section, an insurer is required to report any action taken by it against a physician if the action relates to unprofessional conduct or negligence in treatment by the physician. Again, the MEB may withhold reporting the action to the public if the board determines that the action was done for business or economic reasons.

i. A description of any exclusion from participation in the Medicare program and federally approved or funded state health care programs within the preceding 10 years that is required to be reported to the MEB by the federal Department of Human Services under 42 C.F.R. s. 1001.2005.

j. A description of any medical malpractice claims paid by the patients compensation fund or other insurer within the preceding 10 years that is reported to the MEB under s. 655.26, Stats., and a description of any amount of settlement or award to a claimant in a medical malpractice action within the preceding 10 years that is required to be reported to the MEB by the director of state courts under s. 655.45, Stats.

k. Any other information required by the MEB by rule.

The information that is made available to the public under the bill must be reported in nontechnical language. Dispositions of paid medical malpractice claims must be reported in a minimum of three graduated categories, indicating the level of significance of the amount of the award or settlement. Information concerning paid medical malpractice claims must be given context by comparing the physician's medical malpractice judgment awards and settlements to the experience of other physicians in the same specialty. Information concerning medical malpractice settlements must include the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred."

The bill requires the MEB to utilize links to other websites that contain information on individual physicians that the board is otherwise required to provide.

The bill expressly provides that physicians are required to provide any information requested by the MEB that the MEB determines is necessary to comply with the section. The MEB is required to provide a physician with a copy of the information about him or her prior to its initial release and prior to the inclusion of any change in the information. A physician must be given a reasonable time to correct factual inaccuracies that appear in the information before the information is released to the public. Information that is made available by the MEB under the provisions of the bill is not an exception to the hearsay rule under s. 908.03 (8), Stats., and is not self-authenticating under s. 909.02, Stats.

The MEB by rule is required to determine whether and the extent to which the provisions of the bill apply to a physician who holds a temporary license to practice medicine and surgery.

Under the bill, the costs incurred by the DRL to implement the draft are funded by a surcharge on physicians' biennial license renewal fees. The DRL is directed to determine the amount necessary to fund its costs and include that amount in the department's biennial recommendation for changes in license renewal fees to cover costs funded by the fees.

Finally, Senate Bill 318 expressly requires that DHFS rules relating to health care information under ch. 153, Stats., include procedures affording health care providers the opportunity to correct health care information. Currently, the DHFS is directed to promulgate administrative rules, with the approval of the Board on Health Care Information, to, among other things, establish procedures under which health care providers are permitted to review, verify and comment on health care information collected under ch. 153, Stats. [s. 153.75 (1) (b), Stats.] Under s. 153.45 (5), Stats., DHFS may not release any health care information that is subject to those rules until there is compliance with the verification, comment and review procedures.

DD:rv:jal

APPENDIX 1

JOINT LEGISLATIVE COUNCIL

s. 13.81, Stats.

OFFICERS

Cochairperson
FRED A. RISSER
Senate President
5008 Risser Road
Madison 53705-1365

Cochairperson
CAROL KELSO
Assembly Representative
416 East Le Capitaine Circle
Green Bay 54302-5153

SENATORS

BRIAN BURKE
2029 North 51st Street
Milwaukee 53208-1747

GARY R. GEORGE
1100 West Wells St., #1711
Milwaukee 53233-2326

CHARLES J. CHVALA
1 Coach House Drive
Madison 53714-2718

RICHARD GROBSCHMIDT
912 Lake Drive
South Milwaukee 53172-1736

ROBERT L. COWLES
300 W. Saint Joseph St., #23
Green Bay 54301-2048

JUDITH ROBSON
2411 East Ridge Road
Beloit 53511-3922

MICHAEL G. ELLIS
1752 County Road GG
Neenah 54956-9730

PEGGY ROSENZWEIG
6236 Upper Parkway North
Wauwatosa 53213-2430

JON ERPENBACH
2385 Branch Street
Middleton 53562-2808

DAVID ZIEN
1716 63rd Street
Eau Claire 54703-6857

REPRESENTATIVES

PETER BOCK
4710 West Bluemound Road
Milwaukee 53208-3648

SCOTT R. JENSEN
850 South Springdale Road
Waukesha 53186-1402

STEVEN FOTI
1117 Dickens Drive
Oconomowoc 53066-4316

SHIRLEY KRUG
6105 West Hope Avenue
Milwaukee 53216-1226

STEPHEN J. FREESE
310 East North Street
Dodgeville 53533-1200

MARLIN D. SCHNEIDER
3820 Southbrook Lane
Wisconsin Rapids 54494-7548

JOHN GARD
481 Aubin St., PO Box 119
Peshtigo 54157-0119

LORRAINE M. SERATTI
HC-2, Box 558
Florence 54121-9620

GREGORY HUBER
406 South 9th Avenue
Wausau 54401-4541

JEFF STONE
7424 West Forest Home Ave.
Greenfield 53220-3358

Jane R. Henkel, Acting Director, Legislative Council Staff
1 East Main Street, Suite 401, P.O. Box 2536, Madison, Wisconsin 53701-2536

APPENDIX 2

DISCIPLINE OF HEALTH CARE PROFESSIONALS, SPECIAL COMMITTEE ON

OFFICERS

Chairperson

JOANNE HUELSMAN
Senator
235 West Broadway, Ste. 210
Waukesha 53186-4832

Secretary

FRED A. RISSER
Senator
5008 Risser Road
Madison 53705-1365

Vice Chairperson

GREGG UNDERHEIM
Representative
1652 Beech Street
Oshkosh 54901-2808

REPRESENTATIVES

DAVID CULLEN
2845 North 68th Street
Milwaukee 53210-1206

LORRAINE SERATTI
HC-2, Box 558
Florence 54121-9620

FRANK URBAN
3645 Emberwood Drive
Brookfield 53005-2388

SHELDON WASSERMAN
3487 North Lake Drive
Milwaukee 53211-2919

PUBLIC MEMBERS

KEITH R. CLIFFORD
Attorney
Clifford & Reuter, S.C.
44 East Mifflin St., Ste. 800
Madison 53703-2800

CANDICE FREIL
Vice President-Health Services
PrimeCare Health Plan
N8 W33847 Forest Ridge Dr.
Delafield 53018

KERMIT NEWCOMER, M.D.
Retired Physician
Gunderson Clinic, Ltd.
N2028 Wedgewood Drive East
LaCrosse 54601-7175

JERRY NOACK
Director, Physician Assistant Program
UW-Madison Medical School
1300 University Avenue, Rm. 1050
Madison 53706-1532

RICHARD G. ROBERTS, M.D.
Professor, Dept. of Family Medicine
UW-Madison Medical School
777 South Mills Street
Madison 53715-1896

SUSAN ROSENBERG
Attorney, Domnitz, Mawicke, Goisman & Rosenberg, S.C.
1509 North Prospect Avenue
Milwaukee 53202-2323

BARBARA SCHULTZ
Owner
Appearances at Alma's
609 Crestview Drive
Menomonie 54751-4103

JANET SCHULZ
Vice President
Medical Staff Services
Waukesha Memorial Hospital
N8W29323 Windrift Lane
Waukesha 53188-9409

MARY K. WOLVERTON
Attorney, Peterson, Johnson & Murray, S.C.
733 N. Van Buren St., 6th Fl.
Milwaukee 53202-4705

STUDY ASSIGNMENT: The Committee is directed to study procedures for imposition of discipline for alleged cases of patient neglect or unprofessional conduct by health care-related examining boards and affiliated credentialing boards identified by the Special Committee, for the purpose of ensuring that such procedures are effective, fair and consistent. The Special Committee shall report its recommendations to the Joint Legislative Council by May 1, 1999. [Based on Assembly Amendment 3 to Assembly Substitute Amendment 1 to 1997 Assembly Bill 549.]

Established and Chairperson appointed by a June 24, 1998 mail ballot; members appointed by a September 4, 1998 mail ballot.

16 MEMBERS: 2 Senators; 5 Representatives; and 9 Public Members.

LEGISLATIVE COUNCIL STAFF: Don Dyke, Senior Staff Attorney; Laura Rose, Senior Staff Attorney; and Kathy Follett, Administrative Staff.

APPENDIX 3

State of Wisconsin

JOINT LEGISLATIVE COUNCIL

Special Committee on Discipline of Health Care Professionals
Senator Joanne Huelsman
Chairperson

Committee Staff:
One East Main Street, Suite 401
P.O. Box 2536
Madison, WI 53701-2536
Telephone: (608) 266-1304
Fax: (608) 266-3830
Email: leg.council@legis.state.wi.us

April 15, 1999

TO: MEMBERS, JOINT COMMITTEE ON FINANCE

FROM: Senator Joanne Huelsman, Chairperson, Special Committee on Discipline of Health Care Professionals

The Joint Legislative Council's Special Committee on Discipline of Health Care Professionals is directed to study procedures for the imposition of discipline for alleged cases of patient neglect or unprofessional conduct by health care-related examining boards and affiliated credentialing boards, for the purpose of ensuring that such procedures are effective, fair and consistent. To date, the Special Committee has held six meetings.

Among the topics reviewed by the Special Committee are: (1) recent efforts of the Department of Regulation and Licensing (DRL) to enhance the efficiency and effectiveness of the credential holder disciplinary process; and (2) the provisions of 1997 Wisconsin Act 311, which contains a variety of provisions relating to regulation of physicians by the Medical Examining Board (MEB) and the DRL. The Governor's biennial budget, 1997 Senate Bill 45 and 1997 Assembly Bill 133, contains two appropriation requests that relate to these topics.

One of the budget appropriations provides $541,000 PR for 5.0 project paralegal and 2.0 project regulation compliance investigator positions in order to extend the enforcement pilot project in the department's Division of Enforcement until June 30, 2001. The Joint Committee on Finance originally approved the pilot project and provided funding and authorization for the seven positions beginning October 1, 1998, to temporarily increase DRL enforcement staff. The pilot project was established in order to assist the Division of Enforcement in moving cases more quickly through the "legal action stage" of the complaint handling process. The "legal action" stage follows the investigative stage and only the more serious cases in which there is evidence of a violation tend to progress to this stage. The stage involves determinations as to the appropriate method of resolving a case and if the case cannot be resolved at this stage, the case moves to the formal hearing stage.

During its deliberations, the Special Committee learned that the enforcement pilot project has been successful in expediting the handling of cases through the legal action stage, thereby

reducing the number of disciplinary cases pending legal action. The expedient handling of disciplinary cases by the DRL is very important for an effective discipline process and for public confidence in that process. The Special Committee concluded that it is important to continue the pilot project and therefore supports the extension of the project included in the biennial budget bill.

Another DRL provision in the biennial budget bill appropriates $278,100 PR to:

3. Maintain a toll-free telephone number, pursuant to 1997 Wisconsin Act 311, to receive reports of allegations of unprofessional conduct, negligence or misconduct involving a physician; and

4. Fund positions authorized under Act 311 for the purpose of providing staff to the MEB (1.5 program assistant positions and 1.5 legal assistant positions).

The enactment of 1997 Wisconsin Act 311 addressed a number of concerns regarding the physician disciplinary process and reflected the importance that the Legislature and the public give to that process. The Special Committee concluded that additional staff for the MEB will enhance the efficiency and fairness of the physician disciplinary process and that the toll-free telephone number will enhance public access to and confidence in that process. Therefore, the Special Committee supports the recommended funding to complete the implementation of the provisions of Act 311.

On behalf of the Special Committee on Discipline of Health Care Professionals, I urge members of the Joint Committee on Finance to carefully consider the Special Committee's support of the above budget provisions as the Finance Committee engages in its difficult task of recommending a budget for consideration by the full Legislature.

Thank you for your attention to this matter.

JH:wu:kjf;kjf;rv

APPENDIX 4

COMMITTEE MATERIALS

Staff Materials

1. Staff Brief 98-3, *Overview--State Discipline of Health Care Professionals* (September 29, 1998)

2. Memo No. 1, *Department of Regulation and Licensing: Ad Hoc Enforcement Advisory Committee Recommendations* (October 7, 1998).

3. Memo No. 2, *Massachusetts Law on Individual Physician Profiles* (December 10, 1998).

4. Memo No. 3, *Information From the Federation of State Medical Boards of the United States, Inc.*. (December 10, 1998). (Attachments distributed to Committee Members only.)

5. Memo No. 4, *The Health Care Quality Improvement Act* (December 11, 1998).

6. Memo No. 5, *Purpose of Medical Examining Board; Definition of "Unprofessional Conduct" on Part of Physicians* (January 12, 1999).

7. Memo No. 6, *Issues Relating to Medical Examiners: Death Certificate Completion and Reporting to the Medical Examining Board* (January 12, 1999).

8. Memo No. 7, *Department of Regulation and Licensing Biennial Budget Requests of Interest* (January 12, 1999).

9. Memo No. 8, *Issues Relating to Medical Examining Board Disciplinary Procedure* (January 12, 1999).

10. Memo No. 9, *Required Reporting and Records Provided to the Medical Examining Board* (January 13, 1999).

11. Memo No. 10, *Crimes Information Provided to the Department of Regulation and Licensing* (March 2, 1999).

12. Memo No. 11, *Draft Revision of Section 146.38, Stats., Prepared by State Medical Society of Wisconsin Working Group* (March 3, 1999).

13. Memorandum, *Comments From Committee Member Mary Wolverton on Drafts Before the Committee* (April 20, 1999). (Distributed to Committee Members only.)

Other Materials

1. Presentation of Marlene A. Cummings, Secretary, Wisconsin Department of Regulation and Licensing (October 8, 1998). (Distributed to Committee Members only.)

2. Pamphlet, *Statewide Physician Health Program--Compassionate assistance for Wisconsin physicians* (December 1997).

3. Handout, *Agreement by the State Medical Society of Wisconsin and the Medical Examining Board for a Statewide Impaired Physician Program* (September 12, 1984).

4. Testimony submitted by Walter R. Schwartz, M.D., Medical Examining Board (October 8, 1998).

5. Testimony submitted John C. LaBissoniere, State Medical Society of Wisconsin (October 8, 1998).

6. Testimony submitted by Mark L. Adams, General Counsel, State Medical Society of Wisconsin (October 8, 1998).

7. Booklet, *Passport to Excellence, Visiting Fellowships*, University of Wisconsin (UW)-Madison Continuing Medical Education (undated). (Distributed to Committee Members only.)

8. "Diagnoses and the Autopsies Are Found to Differ Greatly," *The New York Times* (Wednesday, October 14, 1998).

9. Flow chart of hospital disciplinary process, submitted by Richard Hendricks, M.D., Medical Director, St. Mary's Hospital, Madison (undated).

10. Form, *Madison (Wisconsin) Hospitals Medical Staff Application*, submitted by Richard Hendricks, M.D., Medical Director, St. Mary's Hospital, Madison (undated).

11. Handout, *Physician Monitoring in the Health Plan Setting*, submitted by Steven Baker, M.D., Senior Medical Director, and Wendy Potochnik, R.N., Director, Quality Management PrimeCare Health Plan, Inc. (November 18, 1998).

12. Testimony submitted by Don C. Prachthauser, Wisconsin Academy of Trial Lawyers (November 18, 1998).

13. Testimony submitted by George M. Mejicano, M.D., and Thomas C. Meyer, M.D., Office of Continuing Medical Education, Madison (November 18, 1998).

14. Handout, *Monitoring Physician Quality*, submitted by Richard Roberts, M.D., Professor of Family Medicine, UW-Madison Medical School (November 18, 1998).

15. Testimony submitted by Donald R. Rittel, Department of Regulation and Licensing (December 18, 1998).

16. Executive Summary: *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*, Task Force on Health Care Workforce Regulation, Pew Health Professions Commission (October 1998).

17. Newspaper articles relating to the revocation of Dr. M. Terry McEnany's medical license, *Leader-Telegram* (February 7, 1999).

18. Letter, from Arthur Thexton, Prosecuting Attorney, Department of Regulation and Licensing (February 24, 1999).

19. Letter, from Barbara A. Rudolph, Ph.D., Director, Bureau of Health Information, Department of Health and Family Services (March 1, 1999).

20. Article, *FTC jumps on ads touting wonders of unproven care*, American Medical News (February 8, 1999). (Distributed to Committee Members only.)

21. Memorandum, *Fiscal Estimates for WLCS: 0015/P1*, from Gail Riedasch, Budget Manager, Department of Regulation and Licensing (March 4, 1999).

22. Materials distributed at the request of Public Member Candice Freil.

23. Draft letter to Joint Committee on Finance (March 10, 1999). (Distributed to Committee Members only.)

24. Letter to Joint Committee on Finance (April 15, 1999). (Distributed to Committee Members only.)

25. Chart, *Complaints Pending 1988-1998*, distributed by the Medical Examining Board (undated). (Distributed to Committee Members only.)

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Jorge Gomez, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: information@oci.state.wi.us
Web Address: oci.wi.gov

September 27, 2005

The Honorable Curt Gielow
State Representative
Chair – Medical Malpractice Insurance Task Force
316 N State Capital
Hand Delivered

Dear Representative Gielow:

When I appeared before the Medical Malpractice Task Force on September 8, 2005, I was asked about a LAB report. Let me take this opportunity to get back to you and the other members of the Task Force on the issue of the Fund being "overly conservative" in its reserving. On July 7, 2005, the Fund received the Tillinghast Second Opinion on the Milliman Actuarial Analysis as of September 30, 2004. That second opinion found the Fund reserve "to be reasonable, but conservative" [p.3]. The report also noted that conservatism is appropriate because; the coverage offered is unlimited; there is uncertainty with respect to investment results; there could be contingent liabilities; and if the Fund ran out of money there is no easy source of additional funds.

I would also like to take the opportunity to emphasize that the Fund has been a noted success in helping make Wisconsin medical malpractice market a viable environment where companies compete for business, doctors receive affordable coverage, and patients receive the protections. No other state in the union can attest to this success. Specifically:

- The medical malpractice marketplace in Wisconsin is the most stable anywhere in the country. Providers pay the least amount of premium, including Fund assessments, to receive the most coverage available anywhere in the United States.

- The approximately 20 companies now writing in medical malpractice coverage in Wisconsin create a competitive market for primary coverage. The first layer of coverage is available to any licensed physician practicing in Wisconsin at rates that are simply not available in comparable states.

- For patients who successfully prove a malpractice claim, (close to 90% of the claimants do not), the process of actually recovering an award is much more predictive than in other jurisdictions.

- Medical malpractice insurance is available to any licensed physician who wants to practice in Wisconsin. If a doctor cannot secure coverage in the private market, that doctor can secure first dollar coverage in WHCLIP, Wisconsin's residual pool.

- During the past several years as other states have announced alarming rate increases and problems with availability of malpractice coverage, the assessments of doctors and other healthcare providers participating in the Wisconsin Fund have been reduced by 50%. Assessments have fallen from $40 million to less than $20 million in the last two years.

In 2005 the *Ferdon* decision removal of 'caps' on non-economic damages increased the exposure of the Fund to essentially unlimited liability for non-economic damages. The long-term cost of such increased exposure can be actuarially estimated and assessments adjusted accordingly to ensure adequate reserving for liabilities to be paid in the future. The Fund is well able to manage, through its contracted vendors, such a change in the risk environment.

It has been suggested that one option for a workable solution to continue to control the cost of medical malpractice insurance is that the Fund now begin coverage at $500,000 per occurrence/$1,500,000 annual aggregate. This would be a return to the coverage levels of the early 1990s. The threshold or point, at which the Fund starts paying claims, has increased over time. The threshold history is; $200,000 (1975 – 1987); $300,000 (1987 – 1988); $400,000 (1988 – 1997); $1,000,000 (1997 to present).

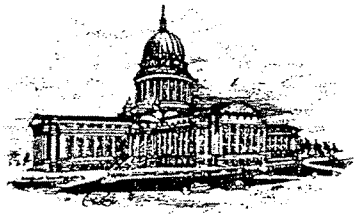
In the interests of finding workable outcomes let me observe that if $500,000/$1,500,000 were to be the statutory amounts now required, health care providers would obtain primary medical malpractice insurance from private insurance companies in those amounts. A reduction in the liabilities placed in the private market will not impact the administration of the Fund. As risk shifts to the Fund, payments to the Fund would increase while payments to private insurers would decrease. The bottom line for such a policy change is that the Fund through its Board of Governors has successfully made such changes before and has conservatively managed its reserves to ensure the continued financial viability of the Fund.

The Injured Patients and Families Compensation Fund has been remarkably successful in fulfilling the charge of supporting a viable medical malpractice environment in the state. As the Task Force considers alternatives, lowering the threshold to $500,000/$1,500,000, should be one option for the task force's consideration.

Thank you for the opportunity to speak to the Task Force. If you need any further information on the Fund please feel free to contact me.

Sincerely,

Jorge Gomez
Commissioner



Wisconsin State Assembly
P.O. BOX 8952 • MADISON, WI 53708

October 10, 2005

Speaker John Gard
Room 211 West, State Capitol
Madison, WI 53702

Dear Speaker Gard:

This letter incorporates the recommendations of the Assembly Medical Malpractice Task Force that you established following a series of Wisconsin Supreme Court decisions in June and July of this year. The recommendations are supported by the entire Task Force, except to the extent that a minority view is expressed at the conclusion of this letter. We believe that the recommendations made by the Task Force appropriately address those court decisions and forward the recommendations to you for your consideration and possible legislative action. The court decisions dealt with the cap on noneconomic damages in medical malpractice cases, coverage of medical residents under the caps and the Injured Patients and Families Compensation Fund ("the Fund"), and consideration by juries of collateral source payments for injuries to plaintiffs in medical malpractice cases. In addition, we are forwarding other recommendations that we feel will improve the medical malpractice system in Wisconsin.

Noneconomic Damage Cap

As you are aware, the Wisconsin Supreme Court declared unconstitutional the statutory cap on noneconomic damages in medical malpractice cases in *Ferdon v. Wisconsin Patients Compensation Fund*, 2005 WI 125 (2005). The majority opinion in that case held that the cap on noneconomic damages was not rationally related to the five legislative objectives summarized by the majority opinion in *Ferdon*.

In the majority opinion, Chief Justice Shirley Abrahamson summarized the five legislative objectives of a cap on noneconomic damages based on 11 findings made by the Legislature in 1975 when it enacted medical liability reform. In 1995, the Legislature enacted a cap because it believed the need for reform set forth in 1975 still existed and the Task Force believes it continues to exist today. We also believe some of the Legislature's findings were misconstrued, oversimplified or simply omitted when the summary objectives were fashioned by the court. For this reason, the Task Force believes any legislation introduced to implement a new cap on noneconomic damages should clarify the objectives embodied in the original 11 findings, including supporting data, and include them in a section related to Legislative Findings.

The Task Force recognizes that the Legislature in 1995 took a carefully balanced approach to compensating medical malpractice plaintiffs in this state. Wisconsin is the only state that

requires health care providers to purchase specified amounts of malpractice insurance coverage and also to participate in a fund that provides unlimited coverage for malpractice liability. Moreover, unlike legislative bodies in some states, the Wisconsin Legislature has set no limits on recovery for economic damages. Therefore, successful malpractice plaintiffs in this state are assured of recovery of their full economic damages. As a balance to this assurance, the Legislature placed a cap on what is assuredly the most unpredictable component of damages--noneconomic losses, largely pain and suffering. The Legislature and the Task Force recognized that this aspect of recovery is often based on emotion, not any predictable standard by which to measure damages. A reasonable cap on noneconomic damages serves as a rational balance to the Legislature's plan to ensure that successful malpractice plaintiffs are able to recover appropriate damages.

Medical liability reform is part of a broad legislative strategy designed to keep health care affordable and available in Wisconsin. The Task Force believes capping noneconomic damages for unquantifiable harms while continuing to allow unlimited recovery for economic damages is crucial to this strategy.

The Task Force is forwarding for your consideration three alternative proposals relating to noneconomic caps:

- Establish a two-tiered system under which injured minors have a higher cap than injured adults. This approach is similar to the two-tiered approach to damages in wrongful death cases.

- Establish a cap on noneconomic damages as the greater of either a base-level cap, or a set amount times each year of life expectancy of the injured patient. Since caps are applied by a judge, rather than a jury, the judge would use a table that could be developed by the Director of State Courts that sets forth life expectancy for persons of different ages. The life expectancy factor would be based solely on the age of the injured patient at the time of the act of malpractice, not on his or her specific health condition either before or after the act of malpractice.

- Cap noneconomic damages at a specific dollar amount. Immunity from liability above this dollar amount could be provided either to health care providers in general, or to health care providers that are participating in the Medical Assistance program.

The Task Force is not recommending the dollar amounts that would be used in the above proposals, but it is rather leaving that for your consideration and the consideration of the Legislature. In determining what dollar amounts to use, we recommend that you consider what other states use as a cap on noneconomic damages, previous Wisconsin Supreme Court rulings, actuarial data and studies presented to the Legislature, the amounts of noneconomic damage awards in medical malpractice cases in Wisconsin, and testimony, data and other information presented to the Task Force. The Task Force believes that this information demonstrates a rational basis for a cap on noneconomic damages because a cap will help maintain the balance described earlier as well as help to achieve legislatively stated objectives.

Any legislation that you might introduce should apply only to acts of malpractice that occur after the effective date of the legislation. The Wisconsin Supreme Court has previously declared invalid an attempt to apply caps on damages retroactively.

In addition, it is recommended that you consider whether any new cap on noneconomic damages be indexed for changes in the Consumer Price Index, as was the cap that was in effect prior to *Ferdon*.

Medical Residents

In June of this year, the Wisconsin Supreme Court rendered a decision in *Phelps v. Physicians Insurance Company of Wisconsin, Inc.*, 2005 WI 85 (2005). In that case, the court held that the statutory cap on noneconomic damages did not apply to a person during his or her medical residency who was not yet a licensed physician and, in the circumstances of the particular case, was not an employee of a hospital. However, the Supreme Court sent the case back to a lower court for a determination of whether or not the medical resident can be considered to be a "borrowed employee" of a hospital.

The recommendations of the Task Force are as follows:

- Require all unlicensed medical residents to have a temporary educational permit starting in their first year, so that they may be considered health care providers.

- Allow sponsors of a graduate medical education program the option of participating in the Fund.

Collateral Sources

The third Wisconsin Supreme Court case that the Task Force discussed is *Lagerstrom v. Myrtle Werth Hospital-Mayo Health System*, 2005 WI 124 (2005). In that case, the court noted that current statutes provide that a jury may receive information about other sources of payments for the injured patient's injuries, in addition to payments from the defendant, but the statutes are silent on how the jury is to use that information. The court held that the jury may not use the information about collateral sources to reduce the award to the injured patient, but may use the information to determine the value of medical services rendered.

The recommendation of the Task Force is as follows:

- Require the jury to reduce the injured patient's award by any collateral source payments received. [Distinctions could be made in this statute depending on the type of collateral source involved; e.g., Medicare or private insurance.] This reduction would be offset by any amount of obligations that the injured patient must reimburse the collateral sources.

Injured Patients and Families Compensation Fund

Currently, health care providers in Wisconsin are required to maintain primary medical malpractice insurance coverage in the amount of $1 million per occurrence and $3 million per year. Damages above these levels are paid from the Fund.

The recommendation of the Task Force is as follows:

- An actuarial audit of the Fund should be undertaken on a periodic basis. Currently, the Legislative Audit Bureau is required to perform a financial audit of the Fund at least once every three years. Actuaries should examine the effect that a conservative estimate of the Fund's future obligations has on premiums paid by health care providers over the long-term.

Medical Malpractice Reduction

The Task Force recommends that the Legislature set as a priority steps to reduce the incidence of medical malpractice in Wisconsin. The Legislature may wish to review recommendations made by the Joint Legislative Council's Special Committee on Discipline of Health Care Professionals in 1999 and subsequent legislation in conjunction with a review of any changes or reforms to the disciplinary system that have been made during the last six years.

Long-Range Issues

The Task Force examined other issues related to the medical malpractice system. However, since it is on a relatively short timeline, the Task Force deferred exploration of those issues to further consideration by other legislators and legislative committees.
The potential recommendations that the Task Force did not take specific action on, but rather recommended further exploration of, are as follows:

- Establish health courts that deal exclusively with medical malpractice cases.

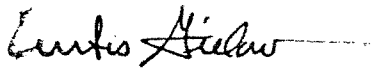
- Provide for legislative oversight of medical malpractice insurance premiums.

Minority Opinion

Representative Bob Ziegelbauer dissents from the recommendations for a noneconomic damage cap because of a concern that they are not sufficiently different from the previous cap that was struck down by the Wisconsin Supreme Court to enable them to survive a constitutional challenge.

Thank you for establishing the Task Force to deal with these important issues and for giving consideration to the recommendations set forth in this letter.

Sincerely,



Representative Curt Gielow, Chair
Assembly Medical Malpractice Task Force

Task Force Members:

Representative Mike Huebsch
Representative Ann Nischke
Representative Jason Fields
Representative Bob Ziegelbauer
Mr. David Strifling
Ms. Mary Wolverton
Dr. Clyde "Bud" Chumbley
Mr. David Olson
Mr. Ralph Topinka

CG:jr:rr